

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8501762

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Sr. M. Scholastica Barbara Battle			2a. DATE OF DEATH MONTH DAY YEAR Jan. 16, 1985			2b. HOUR 2 A. M					
3 SEX Female		4 RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 11-17-01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.					
10. CITY OR TOWN OF DEATH Ridgely		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Gertrude's Priory				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nun/Teacher		12b. KIND OF BUSINESS OR INDUSTRY Church			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Caroline		13c. CITY OR TOWN Ridgely		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE None 21660		
14. FATHER'S NAME FIRST MIDDLE LAST James Battle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Gorham							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-56-0901		17. INFORMANT ADDRESS St. Gertrude's Priory Ridgely, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) CHRONIC CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) CONGESTIVE HEART FAILURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/15 19 85 , to 1/15 19 85 , that (I) (we) last saw the deceased alive on 1/15 19 85 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.											
22b. SIGNATURE Christian E. Jensen MD				DEGREE MD				22c. DATE SIGNED 1/16/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTIAN E. JENSEN MD				22e. ADDRESS P.O. Box 690, DENTON MD 21629							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-85		23c. NAME OF CEMETERY OR CREMATORY St. Gertrude's		23d. LOCATION CITY OR TOWN COUNTY STATE Ridgely Caroline Md.					
24. FUNERAL DIRECTOR NAME John E. Boulais				ADDRESS Greensboro, Md.		25a. DATE REC'D. BY REGISTRAR JAN 22 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

BP

Christian E. Jensen MD PC, Box 680, Denver CO 80202

x

13

1/12 82

82

x

Conductive Heart Failure

Myocardial Infarction
Anterior Wall Myocardial Infarction



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

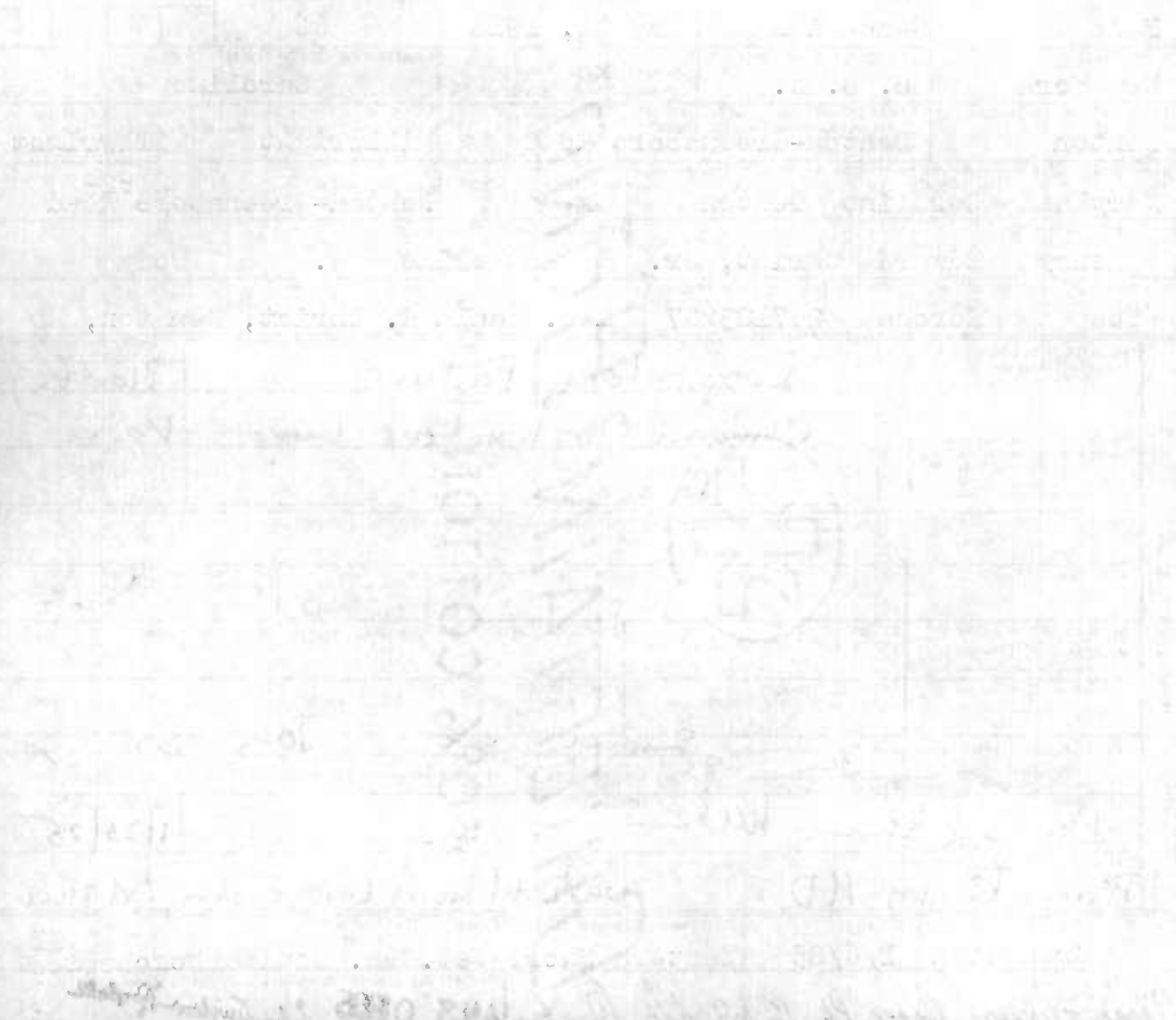
DHMH - 16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 01763

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Henry Edward Christ, Jr.		2a. DATE OF DEATH MONTH DAY YEAR Jan. 22, 1985	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 11, 1918	
6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.		10. CITY OR TOWN OF DEATH Denton	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Denton-Greensboro Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Millwright	
12b. KIND OF BUSINESS OR INDUSTRY Millwright		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13b. STREET ADDRESS Denton-Greensboro Road		13c. CITY OR TOWN Denton	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Edward Christ, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine W. Cody	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean	
17. INFORMANT Mrs. Paula H. Christ, Den ton, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Summer</u> 19 <u>83</u> , to <u>Jan</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Jan</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (that) (did not) view the body after death.			
22b. SIGNATURE <u>P. Gregg Rhodes M.D.</u>		22c. DATE SIGNED 1/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Gregg Rhodes M.D.		22e. ADDRESS 503 Dutchman's Lane, Eastern, Md 21601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/6/85	
23c. NAME OF CEMETERY OR CREMATORY Eastern Shore Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beulah Dorchester MD	
24. FUNERAL DIRECTOR NAME Moore Funeral Home, Pa. 12 1/2 1/2 St. Denton		25a. DATE REC'D. BY REGISTRAR JAN 30 1985	
25b. REGISTRAR'S SIGNATURE John Davidson Rhodes		25c. REGISTRAR'S SIGNATURE	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 5 0 1 7 6 4				
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Agnes Josephine Holt					2a. DATE OF DEATH MONTH DAY YEAR 1-14-85			2b. HOUR M	
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 2-8-11		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.			
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wesleyan Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY none	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Marydel		13e. STREET ADDRESS P.O. Box 45		21649	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Holt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Conley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 072-22-2914		17. INFORMANT ADDRESS Clifford Ennist Richmond Hill, N.Y.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF, (b) Metastatic Cervical Carcinoma DUE TO, OR AS A CONSEQUENCE OF, (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/ 1984 , to 1/14 1985 , that (I) (we) last saw the deceased alive on 12/23 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Samuel Bricker				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel Bricker, MD.				22e. ADDRESS Denton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-23-85		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.			
24. FUNERAL DIRECTOR NAME John E. Boulais				ADDRESS Greensboro, Md.		25a. DATE REC'D. BY REGISTRAR JAN 28 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 1 7 6 5	
1. FOR STATE REGISTRAR		REG. NO.									
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Arthur				Mansfield	1-24-85					11 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		caucasian		4 1 18		66 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Delaware		USA				CAROLINE Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Denton		CAROLINE NSB HOME				Housemover					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Talbot		Easton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 6 Box 122/ 21601			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Linwood		Mansfield Sr. Rhoda		Tribbitt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		213-14-1584		Florence Mansfield see 13e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Bilateral Stroke, Diabetes mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 12</u> , 19 <u>83</u> , to <u>Jan 24</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>Dec 2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
William Lovett MD				1/25/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
William Lovett MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		1-28-85		Spring Hill Cemetery		Easton		Talbot		Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Newnam Funeral Home		Easton, Md.		JAN 29 1985							

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-13. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO. 01766	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Florence Ruth Elizabeth Krabill TODD										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 1 22 1985	
3. SEX Female		4. RACE Cauca.		5. DATE OF BIRTH Jan 28 1907		6. AGE (IN YEARS) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD 1 22 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CAROLINE MD.			
10. CITY OR TOWN OF DEATH Denton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Double Hills Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Double Hills Rd 21629			
14. FATHER'S NAME John William Krabill						15. MOTHER'S MAIDEN NAME Florence M. Bosserman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214348573		17. INFORMANT ADDRESS Mr. Charles D. Todd, Sr., Denton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) VALVULAR HEART DISEASE, CONGESTIVE HEART FAILURE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Christian E. Jensen				TITLE (SPECIFY) DEPUTY		MEDICAL EXAMINER		DATE SIGNED 1/22/85			
EXAMINER'S NAME (TYPE OR PRINT) Christian E. JENSEN M.D.				ADDRESS P.O. Box 690, Denton MD 21629							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/85		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline MD			
24. FUNERAL DIRECTOR NAME Moore Funeral Home PA-13 62nd St Denton						25a. DATE REC'D. BY REGISTRAR Jan 28 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



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